Idaho Medical Home Collaborative Reporting Measures

Measure Type	Measure Name (Bolded) & Description	Numerator Statement	Denominator Statement	Rationale	Measure Source	Submission Timeline	Data Source
Reporting of Measures	**Two (2) Clinical Quality Measures (practice has choice of chronic condition). If Asthma is chosen, all 3 Asthma measures must be reported.** **Two (2) Preventive Clinical Measures; and** **Two (2) Practice Transformation Measures (the two have been identified).**						
Clinical Quality	**Diabetes: Hemoglobin A1c Testing** Percentage of adult patients with diabetes aged 18-75 years receiving one or more A1c test(s) per year.	One or more HbA1c tests performed during the measurement year.	Patients 18-75 years of age as of December 31 of the measurement year who had a diagnosis of diabetes (type 1 or 2). Exclusions apply. Pharmacy and Diagnosis codes are provided.		NCQA NQF # 57	Quarterly	Chart-based
Clinical Quality	**Diabetes: HbA1c Poor control** The percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had HbA1c > 9.0.	Laboratory test result: HbA1c test, Most Recent value > 9.0.	Patients 18-75 years of age who had a diagnosis of diabetes (type 1 or 2) within the past two years. Exclusions apply. Pharmacy and Diagnosis codes are provided.	This measure facilitates the prevention and long-term management of high blood sugar levels for patients diagnosed with diabetes. Clinical guidelines recommend regular HbA1c testing to facilitate patients' ability to improve and sustain acceptable levels (ADA 2009). Studies have shown that improved glycemic control is correlated with a 40% decline in the development of associated microvascular complications (e.g., eye, kidney and nerve diseases) (ADA 2009).	NCQA NQF # 59	Quarterly	Chart-based

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Measure Type	Measure Name (Bolded) & Description	Numerator Statement	Denominator Statement	Rationale	Measure Source	Submission Timeline	Data Source
Clinical Quality	**Controlling High Blood Pressure** The percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled during the measurement year.	Physical exam finding diastolic blood pressure < 90 mmHg, and systolic blood pressure < 140 mmHg, during most recent outpatient encounter.	Patients 18-85 with hypertension. A patient is considered hypertensive if there is at least one outpatient encounter with a diagnosis of hypertension during the first six months of the measurement year.	The U.S. Preventive Services Task Force recommends that clinicians screen adults 18 and older for high blood pressure. This guideline is further endorsed by research studies and clinical trials that have demonstrated decline in costly health outcomes as a direct result of improved blood pressure control. This measure is important in efforts to promote blood pressure control and improve quality of life. *NQF 2011*	NCQA NQF # 18	Quarterly	Chart-based
Clinical Quality	**Hypertension: Blood Pressure Measurement** Percentage of patient visits for patients aged 18 years and older with a diagnosis of hypertension who have been seen for at least 2 office visits, with blood pressure (BP) recorded.	Physical Exam finding systolic and diastolic blood pressure.	Patients with active hypertension who are 18 or older.	Effective Management of blood pressure in patients with hypertension can help prevent cardiovascular events, including myocardial infarction, stroke, and the development of heart failure.	AMA – PCPI NQF # 13	Quarterly	Chart-based
Clinical Quality	**Anti-depressant medication management: (a) Effective Acute Phase Treatment, (b) Effective Continuation Phase Treatment** The percentage of patients 18 years of age and older who were diagnosed with a new episode of major depression, treated with antidepressant medication, and who remained on an antidepressant	1. Effective Acute Phase Treatment: At least 84 days (12 weeks) of continuous treatment with antidepressant medication during the 114-day period following the IPSD (inclusive). The continuous treatment allows gaps in	Total number of patients 12 and older who were diagnosed with a new episode of major depression and treated with antidepressant medication.	Studies have shown that increasing the intensity of depression treatment may be an important key to improvements in outcomes and cost-effectiveness and that appropriate therapy improves the daily functioning and overall health of patients with depression. If pharmacological treatment is initiated, appropriate dosing and continuation of therapy through the acute and	NCQA NQF # 105	Quarterly	Chart-based

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	medication treatment.	medication treatment up to a total of 30 days during the 114-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication. Regardless of the number of gaps, there may be no more than 30 gap days. Count any combination of gaps (e.g., two washout gaps of 15 days each, or two washout gaps of 10 days each and one treatment gap of 10 days). 2. Effective Continuation Phase Treatment: At least 180 days (6 months) of continuous treatment with antidepressant medication (Table AMM-D) during the 231-day period following the IPSD (inclusive). Continuous treatment allows gaps in medication treatment		continuation phases decreases recurrence of depression. Thus, evaluation f length of treatment serves as an important indicator of success in promoting patient compliance with establishment and maintenance of an effective medication regimen.			

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		up to a total of 51 days during the 231-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication. Regardless of the number of gaps, gap days may total no more than 51. Count any combination of gaps (e.g., two washout gaps, each 25 days or two washout gaps of 10 days each and one treatment gap of 10 days).					
Clinical Quality Process	**Screening for Clinical Depression** Percentage of patients aged 12 and older screened for clinical depression using a standardized tool and follow-up plan documented, if appropriate.	Patient's screening for clinical depression is documented and follow-up plan is documented, if appropriate.	Patients 12 years of age and older.	Follow-Up Plan — Proposed outline of treatment to be conducted as a result of clinical depression screen. Such follow-up must include further evaluation if screen is positive and may include documentation of a future appointment, education, additional evaluation and/or referral to a practitioner who is qualified to diagnose and treat depression, and/or notification of primary care provider.	PQRS NQF # 418	Quarterly	Chart-based
Clinical Quality	**Asthma Assessment**	Symptom assessed or active: asthma daytime symptoms	Patients aged 5 to 50 years with diagnosis of	Appropriate treatment of asthma patients requires accurate classification	AMA – PCPI	Quarterly	Chart-based

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Measure Type	Measure Name (Bolded) & Description	Numerator Statement	Denominator Statement	Rationale	Measure Source	Submission Timeline	Data Source
	Percentage of patients aged 5 through 50 years with a diagnosis of asthma and who have been seen for at least 2 office visits, who were evaluated during at least one office visit within 12 months for the frequency (numeric) of daytime and nocturnal asthma symptoms.	quantified. Symptom assessed or active: asthma nighttime symptoms quantified.	active asthma.	of asthma severity. Physician assessment of the frequency of asthma symptoms is the first step in classifying asthma severity.	NQF # 1		
Clinical Quality	**Asthma Pharmacologic Therapy** Percentage of patients aged 5 through 50 years with a diagnosis of mild, moderate, or severe persistent asthma who were prescribed either the preferred long-term control medication (inhaled corticosteroid) or an acceptable alternative treatment.	Number of patients with medication order or medication active: Corticosteroid, inhaled or alternative asthma medication	Patient aged 5 through 50 years with a diagnosis of active asthma or asthma persistent, and at least two office encounters.	Although current guidelines recommend inhaled Corticosteroids as the preferred pharmacological treatment for persistent asthma, other long-term control medications are acceptable alternatives. Long Acting-Inhaled Beta2 Agonists (LABA) are recommended in combination with Inhaled Corticosteroids.	AMA- PCPI NQF # 47	Quarterly	Chart-based
Clinical Quality	**Management Plan for People with Asthma** Percentage of patients for whom there is documentation that a written asthma management plan was provided either to the patient or the patient's caregiver OR, at a minimum, specific written instruction on under what conditions the patient's doctor should be contacted or the patient should go to the emergency room.	Patients for whom there is documentation, at any time during the abstraction period, that a written asthma management plan was provided either to the patient or the patient's caregiver OR at a minimum, a specific written instruction on under what conditions the patient's doctor should be contacted or the patient should go to the emergency room.	Total number of patients who had at least two separate ambulatory visits to your practice site for asthma during the time period January through December.		IPRO NQF # 25	Quarterly	Chart-based

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Measure Type	Measure Name (Bolded) & Description	Numerator Statement	Denominator Statement	Rationale	Measure Source	Submission Timeline	Data Source
Preventive care and screening	**Weight Assessment and Counseling for Children and Adolescents** Percentage of patients 3-17 who had an outpatient visit with a PCP or OB/GYN and who had evidence of BMI percentile documentation, counseling for nutrition and counseling for physical activity during the measurement year.	Physical exam finding BMI percentile; Communication to patient counseling for nutrition; Communication to patient counseling for physical activity	Children 3-17 years of age with at least one outpatient visit with a primary care physician (PCP) or OB-GYN.	Promotion of routine physical activity and healthy eating and lifestyle changes are essential in efforts to improve long-term health outcomes and quality of life, as well as to reduce economic costs associated with obesity and co-morbidities.	NCQA NQF # 24	Quarterly	Chart-based
Preventive care and screening	**Well-Child Visits in the Third, Fifth and Sixth Years of Life** Percentage of members 3-6 years of age who received one or more well-child visits with a PCP during the measurement year.	Received one or more well-child visits with a PCP during the measurement year.	Members age 3-6 years		NCQA NQF # 1516	Quarterly	Chart-based
Preventive care and screening	**Annual Risky Behavior Assessment or Counseling from age 12 to 18** Percentage of children aged 12 to 18 with documentation of assessment or counseling for risky behavior. Four rates are reported: Risk Assessment or Counseling for Alcohol Use, Risk Assessment or Counseling for Tobacco Use, Risk Assessment or Counseling for Other Substance Abuse, Risk Assessment or Counseling for Sexual Activity.	Documentation of assessment or counseling for risky behavior during the past 12 months. Four rates are reported: Risk Assessment or Counseling for Alcohol Use, Risk Assessment or Counseling for Tobacco Use, Risk Assessment or Counseling for Other Substance Abuse, Risk Assessment or Counseling for Sexual	Total number of patients between the ages of 12 and 18.	**This measure has been adapted by the work group to include children ages 12 to 18, for annual assessment. NQF # 1507 requires a four-part assessment between ages 15 & 18. NQF # 1406 requires an assessment by age 13.	NCQA, *Adapted* NQF # 1507 NQF # 1406	Quarterly	Chart-based

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Measure Type	Measure Name (Bolded) & Description	Numerator Statement	Denominator Statement	Rationale	Measure Source	Submission Timeline	Data Source
Preventive Care and Screening	**Tobacco Use: Screening & Cessation Intervention** Percentage of patients aged 18 years and older who were screened for tobacco use at least once during the two-year measurement period AND who received tobacco cessation counseling intervention if identified as a tobacco user	Patients who were screened for tobacco use* at least once during the two-year measurement period AND who received tobacco cessation counseling intervention** if identified as a tobacco user	All patients aged 18 years and older who were seen twice for any visits or who had at least one preventive care visit during the two-year measurement period	*Includes use of any type of tobacco ** Cessation counseling intervention includes brief counseling (3 minutes or less), and/or pharmacotherapy	NCQA NQF # 28	Quarterly	Chart-based
Preventive care and screening	**Adult Weight Screening and Follow-Up** Percentage of patients aged 18 years and older with a calculated BMI in the past six months or during the current visit documented in the medical record AND if the most recent BMI is outside of normal parameters, a follow-up plan is documented within the past six months or during the current visit. Normal Parameters: Age 65 years and older BMI > = to 23 and <30 Age 18 – 64 years BMI > = to 18.5 and <25	Patients with BMI calculated within the past six months or during the current visit, and a follow-up plan documented within the past six months or during the current visit if the BMI is outside of normal parameters	Patients age 18 and older who had one or more encounter office visits.	Clinical recommendations are to screen all adult patients for obesity (and underweight for elderly patients) and offer intensive counseling and behavioral interventions to promote sustained weight loss for obese adults. BMI should be calculated at least annually for screening and as needed for management. Annual BMI calculation can also help elderly patients maintain sufficient weight.	QIP NQF # 421	Quarterly	Chart-based
Preventive care and screening	**1. Adult BMI Assessment** Percentage of members 18-74 years of age who had an outpatient visit and who had their body mass index (BMI) documented during the measurement year or the year prior to the	Body mass index documented during the measurement year or the year prior to the measurement year	Members 18-74 of age who had an outpatient visit		Medicaid Adult Core Set, HEDIS/ NCQA		Chart-based

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	measurement year						
Practice Transformation for PCMH ***Enhance Access and Continuity***	**Third next available appointment** Measuring how long it takes to get patients into the schedule based on the third next available appointment.	The length of time from when a patient contacts the practice to request an appointment, to the third next available appointment on his/her clinician's schedule. The practice may measure availability for a variety of appointment types including new patient physicals, routine exams and return-visit exams.		The "third next available" appointment is used rather than the "next available" appointment since it is a more sensitive reflection of true appointment availability. For example, an appointment may be open at the time of a request because of a cancellation or other unexpected event. Using the "third next available" appointment eliminates these chance occurrences from the measure of availability. Count calendar days (e.g. include weekends) and days off. Do not count any saved appointments for urgent visits (since they are "blocked off" on the schedule.)	**NCQA Standard 1, Element A, Factor 1**	Quarterly	Chart-based
Practice Transformation for PCMH ***Enhance Access and Continuity***	**Patient visits that occur with the selected provider/care team.** Percentage of patient visits with patient's selected provider/care team.	Visits with patient's selected provider/care team. The practice may include structured electronic visits (e-visits) or phone visits within these statistics if relevant.	All Patients visits. The practice may include structured electronic visits (e-visits) or phone visits within these statistics if relevant.	The practice notifies patients about the process for choosing a personal clinician and care team and supports the selection process by discussing the importance of having a clinician and care team responsible for coordinating care. The practice documents the patient/family's choice of clinician and practice team. These activities supports continuity of care. The practice monitors the percentage of patient visits that occur with the selected clinician and team. The practice may include structured electronic visits (e-visits) or phone visits within these	**NCQA Standard 1, Element D, Factor 3**	Quarterly	Chart-based

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				statistics if relevant.			